Arizona Attorney General's Office
Medicaid Fraud Control Unit Complaint Form

ID

Your Information (items in BLUE are required)

Last Name	**First Name**
Address	**City, State**
	Zip Code
Contact Phone Number	**Alternate Phone Number**
Email Address	**Fax Number**

Please complete if you are reporting an abuse, neglect, or financial exploitation case.

Victim's Last Name	**Victim's First Name**
Amount of Loss if reporting exploitation:	
Suspect Last Name	**Suspect First Name**
Suspect Phone Number	
Facility Name	
Address	**City, State**
	Zip Code
Facility Phone Number	
Facility Web site	
Details of Abuse/Neglect or Exploitation	
Witness Last Name	**Witness First Name**
	Phone Number

Please complete if you are reporting Medicaid fraud.

Medicaid Provider	
Address	**City, State**
	Zip
Phone Number	
Details of Medicaid Fraud	

If you have contacted any other agencies, please include any names or case numbers:

DECLARATION: By submitting this form electronically, I declare under penalty of perjury under the laws of the State of Arizona that the information in this complaint is true and accurate.

Name **Date**

Thank you for completing this form.
The filing of this complaint does not ensure an investigation will be initiated.